Medical Part 1 – History and Physical for overnight students and students participating on a sports team

Health Center – School Year 2024-25

Student's Name (Last, First, Middle): Click or tap here to enter text.

Birthday (Mo. Day Yr.): Click or tap to enter a date.

Sex:  M  F

Address (Number, Street, City, Zip): Click or tap here to enter text.

Phone No.: Click or tap here to enter text.

Parent/Guardian Names: Click or tap here to enter text.

Where do you usually take your child for routine medical care?

* Name: Click or tap here to enter text.
* Address: Click or tap here to enter text.
* Phone No.: Click or tap here to enter text.

Where do you usually take your child for dental care?

* Name: Click or tap here to enter text.
* Address: Click or tap here to enter text.
* Phone No.: Click or tap here to enter text.

From what other source does your child receive health care?

* Name: Click or tap here to enter text.
* Address: Click or tap here to enter text.
* Phone No.: Click or tap here to enter text.

# ASSESSMENT OF STUDENT HEALTH

To the best of your knowledge, has your child had any problem with the following? Please check "Yes" or "No" for each.

Allergies (Food, Insects, Drugs, Latex):  Yes  No

* Comments: Click or tap here to enter text.

Allergies (Seasonal):  Yes  No

* Comments: Click or tap here to enter text.

Asthma or Breathing Problems:  Yes  No

* Comments: Click or tap here to enter text.

Behavioral or Emotional Problems:  Yes  No

* Comments: Click or tap here to enter text.

Birth Defects:  Yes  No

* Comments: Click or tap here to enter text.

Bleeding Problems:  Yes  No

* Comments: Click or tap here to enter text.

Cerebral Palsy:  Yes  No

* Comments: Click or tap here to enter text.

Dental:  Yes  No

* Comments: Click or tap here to enter text.

Diabetes:  Yes  No

* Comments: Click or tap here to enter text.

Ear Problems or Deafness:  Yes  No

* Comments: Click or tap here to enter text.

Head Injury:  Yes  No

* Comments: Click or tap here to enter text.

Heart Problems:  Yes  No

* Comments: Click or tap here to enter text.

Hospitalization (When, Where):  Yes  No

* Comments: Click or tap here to enter text.

Lead Poisoning/Exposure:  Yes  No

* Comments: Click or tap here to enter text.

Learning Problems/Disabilities:  Yes  No

* Comments: Click or tap here to enter text.

Limits on Physical Ability:  Yes  No

* Comments: Click or tap here to enter text.

Meningitis:  Yes  No

* Comments: Click or tap here to enter text.

Prematurity:  Yes  No

* Comments: Click or tap here to enter text.

Problem with Bladder:  Yes  No

* Comments: Click or tap here to enter text.

Problem with Bowels:  Yes  No

* Comments: Click or tap here to enter text.

Problem with Coughing:  Yes  No

* Comments: Click or tap here to enter text.

Seizures:  Yes  No

* Comments: Click or tap here to enter text.

Serious Allergic Reactions:  Yes  No

* Comments: Click or tap here to enter text.

Sickle Cell Disease:  Yes  No

* Comments: Click or tap here to enter text.

Speech Problems:  Yes  No

* Comments: Click or tap here to enter text.

Surgery:  Yes  No

* Comments: Click or tap here to enter text.

Other:  Yes  No

* Comments: Click or tap here to enter text.

Does your child take any medication?

Yes  No

Name of medication: Click or tap here to enter text.

## Is your child on any special treatments? (nebulizer, epi-pen, etc.)

Yes  No

Treatment: Click or tap here to enter text.

## Does your child require any special procedures? (catheterization, etc.)

Yes  No

Please describe: Click or tap here to enter text.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: Click or tap to enter a date.

Parent/Guardian Printed Name: Click or tap here to enter text.

PB/LB/cic:2/6/24